Physicians' Ethical Responsibilities in Addressing Racial and Ethnic Healthcare Disparities

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Patients belonging to racial and ethnic minority populations continue to receive lesser-quality healthcare relative to other patients, even when controlling for relevant demographic variables. Such disparities represent a significant challenge for physicians who are ethically committed to serving all patients equally, irrespective of personal characteristics. Accordingly, this report explores the ethical obligations of individual physicians and the medical profession as they pertain to racial and ethnic disparities in healthcare.

To address these disparities, the AMA Council on Ethical and Judicial Affairs recommends that physicians customize the provision of medial care to meet the needs and preferences of individual patients. Moreover, physicians must learn to recognize racial and ethnic healthcare disparities and critically examine their own practices to ensure that inappropriate considerations do not affect clinical judgment. Physicians can also work to eliminate racial and ethnic healthcare disparities by encouraging diversity within the profession, continuing to investigate healthcare disparities, and supporting the development of appropriate quality measures.

Key words: health disparities ■ ethics ■ race/ethnicity ■ patient-centered care

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INTRODUCTION

Despite the advances in social equality achieved over the last half century, many individuals remain disadvantaged due to personal characteristics such as race or ethnicity. In the context of healthcare, considerable evidence indicates that racial and ethnic minority populations have worse health outcomes than other groups.[1,2] These discrepancies persist even when controlling for variables such as access to insurance, educational level and income.[2]

While certain differences in medical care among subpopulations may be acceptable when based upon medical necessity or patient preferences,[3] differences in outcomes that are not directly attributable to such considerations are problematic. These disparities represent a significant challenge for physicians who are ethically committed to serve all patients equally, irrespective of personal characteristics. Accordingly, this report explores the ethical obligations of individual physicians and the medical profession as they pertain to racial and ethnic disparities in healthcare. The recommendations presented at the end of this report have been voted on and adopted as official policy of the American Medical Association (AMA) by the Association's House of Delegates.

Available clinical evidence consistently indicates that patients from minority populations are less likely than whites to receive needed services, including clinically necessary procedures.[4] In 2004, the Agency for Healthcare Research and Quality's (AHRQ's) *National Healthcare Disparities Report* revealed significant quality differentials in the care received by minority patients.[4] Furthermore, the Institute of Medicine (IOM) report, *Unequal Treatment*, found that such quality differentials persist even in the presence of equal insurance coverage and equivalent access to healthcare.[5]

Examples of disparate treatment are well documented, especially among African-American populations.[6] For instance, African Americans are more likely to die from cardiovascular complications but are less likely than whites to undergo coronary artery bypass grafts or angioplasty procedures.[2,7,8] Although they constitute a disproportionate percentage of individuals with end-stage renal disease, African Americans are also less likely to be referred for kidney transplant evaluation, to be placed on an organ recipient waiting list or undergo transplant surgery, even when adjusting for socioeconomic and health status variables.[9,10] These patients, additionally, face higher rates of diabetes-related complications[11,12] and have worse survival rates following

cancer diagnosis than do white patients.[13] Paradoxically, African Americans are also more likely to receive undesirable services such as diabetes-related lower-limb amputations.[14]

Although the preponderance of research findings has focused upon African Americans, similar disparities have been documented among Hispanic, Asian-American/Pacific-Islander and Native-American populations as well.[15] For example, Hispanic patients are less likely to receive cholesterol management services or appropriate pharmacotherapy following acute cardiovascular events.[15] Hispanic patients are also less likely to receive cardiovascular procedures such as percutaneous transluminal coronary angioplasties or coronary artery bypass grafts.[16] Quality disparities are likewise documented amongst Native-American diabetes patients, who are less likely to have their LDL cholesterol and HbA1C levels tested as part of their diabetes management regimens.[15] Clinical studies additionally indicate that Asian-American/Pacific-Islander patients receive fewer cancer screening services such as fecal occult blood tests or mammograms.[17]

Overall, the AHRQ's National Healthcare Disparities Report estimated that African-American patients receive poorer quality care than whites on two-thirds the quality measures under examination.[4] Hispanics and Native Americans likewise fared worse on approximately one-third of these measures.[4] Asian-Americans/Pacific Islanders also received lesser-quality of care on one-tenth of the available quality measures.[4] In light of these and other documented disparities, the Centers for Disease Control and Prevention have recently concluded that little tangible progress has been made toward assuring the equitable treatment of all patients.[18] Were these disparities in healthcare to be eliminated, five times as many lives could be saved as are saved by advances in medical technology.[19]

CAUSES OF HEALTHCARE DISPARITIES

Several factors are associated with disparate healthcare among minority population groups. These include cultural and linguistic factors, the influence of stereotypes and bias, and the dynamics of patient–physician interactions.

Cultural and Linguistic Factors

Communication difficulties related to cultural, ethnic or racial differences between patients and physicians are known to be more prominent when both parties are from different racial backgrounds, as compared to racially concordant patient-physician pairings.[20] Poor communication can impede the delivery of quality healthcare by compromising physicians' abilities to understand patients' explanations.[21] Poor communication can also compromise patient autonomy by limiting individuals' understanding of clinical information or the choice of available interventions.[22] It also has been demonstrated that physicians are less likely to engage in participatory decision-making practices with minority patients.[23,24] Taken together, these factors can substantially reduce satisfaction with the use of health services among minority populations.[25]

Cultural and linguistic factors can significantly affect patients' levels of health literacy.[26] The Healthy People 2010 project has defined health literacy as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."[27] Low health literacy is correlated with reduced utilization of preventive services and increased reliance upon emergency care.[28] Overall, patients' health literacy impacts the quality of clinical interactions to a much greater extent than does racial concordance between patients and their physicians.[25]

Cultural factors can additionally influence patients' health beliefs.[29] These beliefs, in turn, potentially affect patients' attributions of physical symptoms and their willingness to seek or adhere to treatment recommendations.[29,30] Patients' cultural backgrounds can also affect the quality of clinical interventions as the use of some traditional remedies may interfere with conventional science-based treatments.[29]

Stereotypes and Bias

Medical decision-making occurs within a context of limited time and limited information. Clinicians must evaluate a range of data, including a history, physical examination and results of diagnostic tests, in the process of identifying treatment options. Even under the best of circumstances, clinical uncertainty is unavoidable, and many clinicians rely upon clinical epidemiology and probability inferences to risk stratify their patients on the basis of demographic or clinical characteristics.[31]

Reliance on demographic characteristics is problematic when physicians inappropriately rely upon these variables as proxies for socioeconomic status or individual behavior.[32] In practice, such inappropriate use has been demonstrated to influence clinical interactions negatively by affecting physicians' evaluation of patients' physical symptoms[32] or decision-making capacities,[33] and ultimately influencing physicians' treatment recommendations.[12] When this occurs, physicians fail to provide the same quality of care to all patients, and affected persons are denied the opportunity to receive individualized healthcare based upon their personal needs and preferences. Physicians, therefore, must recognize the limited predictive validity of racial or ethnic variables within the clinical decision-making process in order to ensure that all patients are treated equally.

Trust and the Patient–Physician Relationship

Trust is fundamental to the clinical relationship because it fosters patients' abilities to make autonomous decisions.[34] However, the diminished quality of clinical encounters between minority patients and their physicians has left many individuals from racial and ethnic groups with the perception that their lives are not equally valued by medical professionals.[35] This results in decreased levels of trust,[36] which is correlated with lessened patient and provider satisfaction, poorer continuity of care, reduced patient adherence to the care plan and diminished health status.[37,38] In contrast, greater levels of trust are associated with patients' increased willingness to seek medical care, utilize preventive services and adhere to treatment recommendations.[39,40] A strong degree of patient–physician trust is therefore critical to enable members of minority populations to seek and receive quality healthcare.[41]

Certain historical interactions between physicians and African Americans have also contributed to the sustained mistrust of physicians or public health officials among minority patients. For example, in the Tuskegee Alabama Syphilis Study, the investigators failed to secure the informed consent of participants, and it was later determined that the harms incurred were not justified by research findings. The widespread criticism following the publication of this study resulted in fear among some minority patients that their rights might be violated in the interest of science.[35,42] Such distrust has contributed to low levels of participation in clinical trials and other medical interventions.[43] In some instances, this distrust also may contribute to higher levels of treatment refusal, although such refusals explain only a small percentage of reported disparities in the utilization of healthcare.[44]

ETHICAL OBLIGATIONS OF PHYSICIANS IN REDUCING DISPARITIES

Physicians are ethically obligated to treat their patients fairly by providing the same quality of care to all individuals in their care.[45] They can achieve this goal by examining their clinical practice for potential sources of bias, providing patient-centered care to all patients and helping to promote diversity within the physician workforce.

Critical Examination of Clinical Practices

Physicians' ethical obligations require them to respect patients' human dignity and rights by providing quality care regardless of medically irrelevant personal characteristics.[46] By adhering to this requirement, physicians can help reduce inequalities in healthcare received by members of minority groups.[47]

To this end, physicians must educate themselves and learn to recognize the causes of health disparities.[48] This can be accomplished in part by acquiring a greater understanding of the cultural or ethnic characteristics that affect patients' beliefs as well as their abilities to conceptualize medical information and participate actively in medical decision making.

Physicians also must examine critically their own practices in an effort to ensure unbiased delivery of healthcare. As potential biases are often subtle, all physicians must scrutinize their own behavior to uncover any unwarranted assumptions based on racial or ethnic characteristics. Physicians should also be alert to the behavior of their colleagues, other healthcare professionals and support staff, and seek to improve any behaviors that might impact negatively upon patients' clinical encounters or otherwise contribute to healthcare disparities. Moreover, as the majority of medical services are delivered in hospitals, examining differences in minority patients' utilization of services that are recognized as indicators of quality healthcare should become an integral part of peer review and accreditation activities.[45,49]

Finally, physicians should help increase awareness of healthcare disparities by engaging in open and broad discussions about the issue in medical school curricula, in medical journals and at professional conferences.[45] Physicians should also advocate for continued research investigating the sources of healthcare disparities. These efforts may include the development of relevant quality measures for use in quality improvement initiatives, which have been demonstrated to reduce healthcare disparities.[50-52]

Provision of Patient-Centered Care

Patient-centered care is an essential component of physicians' ethical obligations to provide compassionate care and to regard responsibility to the patient as paramount.[46] Patient-centered care is characterized by participatory decision-making practices to meet the needs, expectations and preferences of patients.[53] It emphasizes good communication with patients and an understanding of the individual patient's perspectives, such as cultural or religious factors that influence their health beliefs, their communications about medical information and their involvement in medical decision-making.[54] The provision of patient-centered care is effective in increasing patients' trust.[55] Additionally, physicians may benefit from better understanding the complex relationships between patients' beliefs about healthcare and their sociocultural environment.[56,57] Good communication also requires that language barriers be minimized (for example, through the appropriate use of interpreters[58]) so that information is exchanged in a manner that both parties can understand.

Patients from different backgrounds often have varying expectations regarding their interactions with physicians.[59] A culturally sensitive patient–physician interaction, therefore, entails a negotiation process between the

physician's and the patient's perceptions of what processes and actions are appropriate.[60] Physicians can empower patients by encouraging them to ask questions and to make their healthcare preferences known.[61]

Physicians should strive to ensure that the presence of cultural or linguistic barriers does not compromise the quality of clinical encounters.[51] All medical services must be provided in accordance with patients' needs and current standards of practice.[60]

Promoting Diversity in the Healthcare Workforce

Minority physicians may be more adept at serving minority patients[20] and are more likely to practice in underserved minority communities.[61] However, while approximately one-quarter of the American population is composed of African Americans, Hispanics and American Indians, <6% of the nation's physicians represent these minority populations.[62] Accordingly, the Sullivan Commission's report, *Missing Persons: Minorities in the Health Professions*, has recommended that the medical profession take active steps to increase the number of minorities in the health professions as one means to reduce healthcare disparities.[63] Individual physicians can also assist in encouraging diversity within the medical work force by volunteering as mentors to minority students or otherwise encouraging minority students' interests in pursing medical careers.[63]

CONCLUSION

Variations in treatment that are based on medically irrelevant considerations such as race or ethnicity constitute healthcare disparities and may be detrimental to the health and well-being of minority patients. Physicians are ethically obligated to treat all patients equally, providing all medical care in accordance with accepted standards of practice, and patients' individual needs and preferences. In order to address the disparate treatment of patients, physicians must recognize the limited predictive validity of clinical assumptions based upon culture or ethnicity. They must also communicate effectively with their patients and enable them to engage in participatory decision-making practices. Finally, physicians must critically examine their own clinical practices as well as those of their colleagues and staff, with the intention of improving any behaviors that might contribute to the differential treatment of minority patients. Ultimately, the adoption of these measures can help physicians provide patient-centered care that is sensitive to the cultural and ethnic characteristics that influence healthcare decisions without relying on stereotypes.

RECOMMENDATIONS

Differences in treatment that are not directly attributable to variances in clinical needs or patient preferences constitute disparities in healthcare. Among racial and ethnic minority populations, such disparities may contribute to health outcomes that are considerably worse than those of majority populations. This represents a significant challenge for physicians who are ethically called upon to serve patients without regard to medically irrelevant personal characteristics. The following guidelines are intended to help reduce racial and ethnic disparities in healthcare:

1) Physicians must strive to offer the same quality of care to all their patients irrespective of personal characteristics such as race or ethnicity. The provision of care should be customized to meet patient needs and preferences.
2) Physicians must learn to recognize racial and ethnic healthcare disparities and should examine their own practices to ensure that inappropriate considerations do not affect clinical judgment.
3) Physicians should work to eliminate biased behavior toward patients by other healthcare professionals and staff who come into contact with patients. Inappropriate discrimination toward any patient or group of patients must not be permitted.
4) Participatory decision-making should be encouraged with all patients. This requires trust, which in turn requires effective communication. Physicians should seek to gain greater understanding of cultural or ethnic characteristics that can influence patients' healthcare decisions. Physicians should not rely upon stereotypes; they should customize care to meet the needs and preferences of individual patients.
5) Physicians should recognize and take into account linguistic factors that affect patients' understanding of medical information. In particular, language barriers should be minimized so that information is exchanged in a manner that both parties can understand.
6) Increasing the diversity of the physician workforce may be an important step in reducing racial and ethnic healthcare disparities. Physicians should therefore participate in efforts to encourage diversity in the profession.
7) Physicians should help increase awareness of healthcare disparities by engaging in open and broad discussions about the issue in medical school curricula, in medical journals, at professional conferences and as part of professional peer-review activities. Research should continue to investigate healthcare disparities, including the development of quality measures.

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